United States Department of Labor
Employees' Compensation Appeals Board

A.W., Appellant	)	
and	)	**Docket No. 17-1350**
	)	**Issued: December 12, 2018**
U.S. POSTAL SERVICE, POST OFFICE, Stratford, CT, Employer	)	

Appearances:
William Bothwell, for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On June 7, 2017 appellant, through her representative, filed a timely appeal from a January 6, 2017 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.[3]

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.; see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

[3] The Board notes that following the January 6, 2017 decision, OWCP received additional evidence. However, the Board's *Rules of Procedure* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this additional evidence for the first time on appeal. *Id.*

ISSUE

The issue is whether appellant has met her burden of proof to establish more than one percent permanent impairment of her left lower extremity, for which she previously received a schedule award.

FACTUAL HISTORY

On February 9, 2010 appellant, a 43-year-old letter carrier, filed an occupational disease claim (Form CA-2), alleging that she developed "[t]arsal tunnel syndrome, and plantar fasciitis" due to factors of her federal employment, which included walking, walking up and down stairs, walking on hard and uneven terrain, and standing on a cement floor. OWCP accepted the claim for left tarsal tunnel syndrome and bilateral calcaneal spurs. Appellant underwent three OWCP-authorized surgeries: a left tarsal tunnel release and radical plantar fasciotomy on May 18, 2010; an excision of left plantar calcaneal spur with fasciectomy and radical fasciectomy for plantar fibromatosis of the left arch on February 1, 2011; and a removal of plantar calcaneal spur on March 5, 2013. OWCP placed her on the periodic compensation rolls as of June 6, 2010. Appellant returned to full-time regular-duty work on May 7, 2013.

On September 17, 2013 appellant filed a claim for a schedule award (Form CA-7). She submitted a September 9, 2013 report of Dr. Martin Pressman, a podiatrist, who opined that she had 16 percent permanent impairment of the left foot based on the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[4]

In another September 9, 2013 report, Dr. Pressman indicated that appellant had been evaluated for maximum medical improvement (MMI) of her left foot. Utilizing Table 16-2 of the A.M.A., *Guides*, he determined that appellant had a class 2 moderate problem under the muscle tendon diagnostic key factor area, which equaled 16 percent permanent impairment of the left foot.

On April 25, 2014 Dr. Morley Slutsky, an OWCP district medical adviser (DMA) and Board-certified occupational medicine specialist, reviewed the medical evidence of record and found that Dr. Pressman's impairment rating was not justified or consistent with impairment methods described in the A.M.A., *Guides* and there were no objective physical examination findings upon which to base an impairment rating. He recommended a second opinion evaluation to determine appellant's employment-related permanent impairment.

In a July 15, 2014 report, Dr. Pressman reiterated his opinion that appellant had 16 percent permanent impairment of the left foot based on Table 16-2 located on page 501 of the A.M.A., *Guides*. He determined that appellant's left foot condition was "similar to and equivalent to the Strained Tendinosis Grid class 2, moderate flexible deformity, and loss of in this case fascial function with scarring and fibromastosis."

On July 25, 2014 Dr. Slutsky continued to find that Dr. Pressman's impairment rating was not justified or consistent with impairment rating methods proscribed in the A.M.A., *Guides* and there were no objective physical examination findings upon which to base an impairment rating.

[4] A.M.A., *Guides* (6th ed. 2009).

He again recommended a second opinion evaluation to determine appellant's permanent impairment.

OWCP referred appellant to Dr. Balazs B. Somogyi, a Board-certified orthopedic surgeon, for a second opinion examination to determine her employment-related permanent impairment. In his September 10, 2014 report, Dr. Somogyi found that appellant had reached MMI. He indicated that the permanent impairment evaluation was based on Table 3-1, page 40, of the A.M.A., *Guides*. The pain pattern was noted to be moderate in nature with the pain disability score between 71 and 100, which resulted in one percent whole person impairment.

In a supplemental report dated September 29, 2014, Dr. Somogyi explained that appellant's one percent whole person impairment was equivalent to two percent impairment of the left lower extremity when using the conversion Table 16-10, page 530, of the A.M.A., *Guides*.

On October 24, 2014 Dr. Slutsky found that Dr. Somogyi's rating was based on pain using Chapter 3, which was unacceptable because pain was already incorporated into the ratings for the accepted diagnoses using the impairment grids in the lower extremity chapter.

In another supplemental report dated June 26, 2015, Dr. Somogyi used Table 16-2 of the A.M.A., *Guides* at page 503, to determine that appellant had a left lower extremity impairment under fracture/dislocation diagnostic class. He explained that the fracture impairment grade was used since in essence fracture was created when the calcaneus spur was removed. Dr. Somogyi opined that appellant had five percent permanent impairment of the left lower extremity for her class 1 calcaneus condition. He further submitted a July 16, 2015 report indicating that his initial impairment rating based on pain should be discarded.

Appellant submitted progress reports dated September 21, 2015, February 4 and 25, and May 23, 2016 from Dr. Pressman who diagnosed fibrosis and scar of the left arch.

On October 7, 2015 Dr. David I. Krohn, a Board-certified internist serving as OWCP's DMA, reviewed the medical evidence of record and determined that appellant's date of MMI was July 15, 2014, the date that Dr. Pressman found that appellant's condition had stabilized and assigned an impairment rating of appellant's left foot. He explained that Dr. Somogyi's second opinion reports failed to utilize an accepted diagnosis for his impairment rating as "no fracture of the calcaneus was diagnosed prior to treatment." Dr. Krohn concluded that there was no basis in the A.M.A., *Guides* for an assignment of appellant's permanent impairment rating for either the left or right lower extremity.

On February 3, 2016 OWCP found a conflict of medical opinion between its second opinion physician, Dr. Somogyi, and its DMA, Dr. Krohn, due to a disagreement of permanent rating assignment for diagnosed conditions of left lower extremity.[5]

On February 22, 2016 OWCP referred appellant to Dr. David B. Brown, a Board-certified orthopedic surgeon, for a referee examination to resolve the conflict.

[5] The Board notes that this appears to have been a typographical error as the January 6, 2017 hearing representative decision correctly noted the conflict as being between Dr. Krohn and Dr. Pressman.

In his March 14, 2016 referee examination, Dr. Brown reviewed a statement of accepted facts (SOAF) and appellant's medical history and records. He noted an accurate history and work-related diagnoses of left tarsal tunnel release, excision of left calcaneal spur, and excision of left plantar fibromatosis. Dr. Brown conducted a physical examination and found that appellant offered no complaints to the right foot and there was zero percent impairment of the right foot. Regarding the left foot, he found a well-healed scar over the left heel, a curvilinear scar extending just posterior to the medial malleolus, and a longitudinal scar over the medial plantar foot. There was not bony deformity of the ankle or foot. There was no soft tissue swelling. The overlying skin was not red or warm. There was some tenderness of the incision just posterior to the medial malleolus, but the Tinel's sign was negative. There was normal dorsalis pedis and posterior tibial pulses with excellent capillary return to the nail beds. There was normal skin sensibility. Active ankle motion was 20 degrees of dorsiflexion with 40 degrees of plantar flexion. There was 10 degrees of passive pronation and 20 degrees of passive supination. Inversion and eversion of the forefoot was done to about 10 degrees in either direction and were accompanied by some mild mid-foot pain. There was mild heel pain on passive dorsiflexion of the foot on direct heel compression and mild tenderness over the medial aspect of the foot. There was no significant neurologic deficit and the ankle reflex was diminished. Dr. Brown concluded that appellant had a one percent whole person impairment or a one percent permanent impairment of the left lower extremity. Utilizing Chapter 3, page 31, of the A.M.A., *Guides*, he found that the pain-related impairment needed to be framed within the context of appellant's subjective complaints of pain without any significant neurologic deficit and he opined that appellant's complaints of pain were consistent with the surgical procedures performed. Dr. Brown explained that this conclusion was further illustrated in the example in section 3.6 wherein complaints of pain to the right foot and ankle following an ankle sprain were noted to be subjective without prominent objective findings and in the absence of physical findings. He asserted that this example noted a pain-related impairment of "[one] percent whole person." Dr. Brown opined that the example noted was quite similar to appellant in regard to her left foot surgeries with ongoing pain, but with limited physical findings. He found that appellant did have a complaint of aching soreness to the left foot which was causally related to her work activities over the past 20 years as a letter carrier and he agreed with Dr. Somogyi that there was a one percent whole person impairment due to surgical treatment to the left foot causally related to her cumulative trauma as a letter carrier. With reference to the pain disability questionnaire (PDQ), Dr. Brown found there to be a moderate disability of 71 with the grade modifier 1 as noted in Table 17-A, page 599. With reference to Table 16-10, page 530, he found that appellant's one percent whole person impairment would convert to a one percent left lower extremity impairment. Dr. Brown determined that appellant had reached MMI as of March 5, 2014, one year following the date of her last surgery.

On April 15, 2016 Dr. Herbert White, Jr., a DMA for OWCP and Board-certified occupational medicine specialist, reviewed the medical evidence of record and concurred with Dr. Brown's MMI date of March 5, 2014. He also concurred with Dr. Brown's impairment rating. Dr. White explained that the use of Chapter 3's pain-related impairment (PRI) system was appropriately applied in this case because appellant presented with a painful condition that could not be rated according to principles outlined in Chapters 4 to 17. Appellant's calcaneal spurs could not be rated in the foot section because there was no appropriate grid. Based on Dr. Brown's objective findings, the DMA concluded that appellant had one percent permanent impairment of the left lower extremity.

By decision dated July 7, 2016, OWCP granted appellant a schedule award for one percent permanent impairment of the left lower extremity. The award ran for 2.88 weeks for the period March 5 to 25, 2014.

On August 3, 2016 appellant requested an oral hearing before a representative of OWCP's Branch of Hearings and Review.

Appellant subsequently submitted a November 2, 2016 progress report from Dr. Pressman who continued to diagnose fibrosis and scar left arch. He also diagnosed tarsal tunnel cicatrix without nerve pain.

On November 18, 2016 appellant's representative requested a review of the written record in lieu of an oral hearing.

In a December 2, 2016 statement, appellant's representative argued that appellant's list of accepted conditions should be expanded and then an appropriate decision should be issued regarding the extent of her lower extremity impairment.

By decision dated January 6, 2017, an OWCP hearing representative conducted a review of the written record and affirmed the prior schedule award decision. He found that OWCP had properly determined that a conflict existed between the opinions of Drs. Krohn and Pressman, and in order to resolve such conflict it properly referred appellant to Dr. Brown for a referee medical examination. The hearing representative affirmed the July 7, 2016 decision, which granted appellant a schedule award for one percent permanent impairment of her left lower extremity, according to the special weight of the medical evidence to Dr. Brown's referee opinion.

LEGAL PRECEDENT

The schedule award provisions of FECA[6] provide for compensation to employees sustaining impairment from loss or loss of use of specified members of the body. FECA, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such determination is a matter which rests in the sound discretion of OWCP. For consistent results and to ensure equal justice, the Board has authorized the use of a single set of tables so that there may be uniform standards applicable to all claimants. The A.M.A., *Guides* has been adopted by OWCP as a standard for evaluation of schedule losses and the Board has concurred in such adoption.[7] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2009.[8]

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability

[6] 5 U.S.C. § 8107; 20 C.F.R. § 10.404.

[7] *See Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000). *See also* 5 U.S.C. § 8107.

[8] *See D.T.*, Docket No. 12-0503 (issued August 21, 2012); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6.6a (March 2017); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

and Health (ICF).[9] Under the sixth edition, the evaluator identifies the impairment class of diagnosis (CDX) condition, which is then adjusted by grade modifiers based on functional history (GMFH), physical examination (GMPE), and clinical studies (GMCS).[10] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX). Evaluators are directed to provide reasons for their impairment rating choices, including the choices of diagnoses from regional grids and calculations of modifier scores.[11]

ANALYSIS

The Board finds that this case is not in posture for a decision.

OWCP accepted that appellant developed left tarsal tunnel syndrome and bilateral calcaneal spurs due to factors of her federal employment. After appellant underwent three authorized left foot surgeries, it granted her a schedule award for one percent permanent impairment of the left lower extremity. It is appellant's burden of proof to submit sufficient evidence to establish the extent of permanent impairment.[12]

The sixth edition of the A.M.A., *Guides* allows for a maximum three percent impairment rating for nonspecific pain that cannot be attributed to a condition addressed elsewhere in the A.M.A., *Guides*. According to section 3.3b, patients' responses on functional assessment instruments will act as modifiers of the percentage impairment they are awarded, but the awards will, in general, primarily reflect objective factors. This is in keeping with the general strategy of the A.M.A., *Guides* to consider pain-related impairment, but to limit the amount of impairment that is awarded for subjective factors. In no circumstances should the PRIs developed using this chapter be considered as an add-on to impairment determinations based on the criteria listed in Chapter 4 to 17. In essence, the PRIs derived according to this chapter are determined in a stand-alone fashion.[13] Examiners should not use Chapter 3 to rate pain-related impairments for any condition that can be adequately rated on the basis of the body and organ impairment systems given in other chapters of the A.M.A., *Guides*.[14]

In the instant case, Dr. Brown referenced Chapter 3, page 31, of the A.M.A., *Guides* and found that the pain-related impairment needed to be framed within the context of appellant's subjective complaints of pain without any significant neurologic deficit and he opined that appellant's complaints of pain were consistent with the surgical procedures performed. He explained that his conclusion was illustrated in the example in section 3.6 wherein complaints of pain to the right foot and ankle following an ankle sprain were noted to be subjective without

[9] A.M.A., *Guides* (6th ed. 2009), p.3, section 1.3, *International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement*.

[10] *Id.* at 494-531.

[11] *See R.V.*, Docket No. 10-1827 (issued April 1, 2011).

[12] *See Annette M. Dent*, 44 ECAB 403 (1993).

[13] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1.6 (January 2010); *see also M.R.*, Docket No. 10-0862 (issued December 23, 2010).

[14] *Id.*

prominent objective findings and in the absence of physical findings. Dr. Brown asserted that this example noted a PRI of "one percent whole person." He opined that the example noted was quite similar to appellant with regard to her left foot surgeries with ongoing pain, but with limited physical findings. The Board finds, however, that Dr. Brown's objective findings also included that active ankle motion was 20 degrees of dorsiflexion with 40 degrees of plantar flexion. There was 10 degrees of passive pronation and 20 degrees of passive supination. Inversion and eversion of the forefoot was done to about 10 degrees in either direction and were accompanied by some mild mid-foot pain. There was mild heel pain on passive dorsiflexion of the foot on direct heel compression and the ankle reflex was diminished. Moreover, with reference to appellant's PDQ score of 71, Dr. Brown utilized Table 17-A on page 599 of Chapter 17 of the A.M.A., *Guides*, which is inappropriate as the PRI method utilizes Chapter 3 of the A.M.A., *Guides*.

The Board finds that Dr. Brown's impairment rating does not comport with the PRI method because it failed to use the appropriate tables and failed to identify nonspecific pain that could not be attributed to a condition addressed elsewhere in the A.M.A., *Guides*. Specifically, it failed to address how the objective range of motion findings impacted appellant's percentage of permanent impairment based on his accepted conditions of left tarsal tunnel syndrome and bilateral calcaneal spurs. Lacking further discussion, the Board finds that this assessment was not appropriate.[15] Consequently, the Board finds that Dr. Brown's impairment rating based on the PRI system does not comport with OWCP's procedures and is insufficient to establish any permanent impairment.[16]

Proceedings under FECA are not adversarial in nature and OWCP is not a disinterested arbiter. The claimant has the burden to establish entitlement to compensation; however, OWCP shares responsibility in the development of the evidence to see that justice is done.[17] Once OWCP undertakes development of the record, it must do a complete job in procuring medical evidence that will resolve the relevant issues in the case.[18] In view of the above-noted deficiencies regarding the findings of Dr. Brown, the decision shall be set aside and the case remanded for further medical development regarding entitlement to an increased schedule award. Following this and any other further development as deemed necessary, OWCP shall issue a *de novo* decision on appellant's schedule award claim.

CONCLUSION

The case is not in posture for decision.

[15] *See M.R., supra* note 13.

[16] *M.M.*, Docket No. 17-0197 (issued May 1, 2018).

[17] *William J. Cantrell*, 34 ECAB 1223 (1983).

[18] *Richard F. Williams*, 55 ECAB 343, 346 (2004).

ORDER

IT IS HEREBY ORDERED THAT the January 6, 2017 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further action consistent with this decision.

Issued: December 12, 2018
Washington, DC

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board